汕尾市医疗保险住院零星报销申请表

收件时间： 年 月 日

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 |  | | | | 性别 | | | | | |  | | | | | 人员类别 | | | | | | 职工/居民 | | | |
| 单位名称 |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 身份证  号码 |  |  |  |  | |  |  | |  |  | |  | |  |  | |  |  | |  |  | |  |  |  |
| 家庭住址 |  | | | | | | | | | | | | 患者联系电话 | | | 固定电话 | | |  | | | | | | |
| 手机号码 | | |  | | | | | | |
| 医院名称 |  | | | | | | | 住院号 | | | | |  | | | 住院时间 | | | 年 月 日至 | | | | | | |
| 年 月 日 | | | | | | |
| 疾病诊断 |  | | | | | | | 发票  张数 | | | | |  | | | 本年度  报销次数 | | | | | |  | | | |
| 申请人  承诺 | 本人承诺提交的报销资料真实准确，未在其它机构享受过医疗待遇，如有隐瞒或欺骗，愿意承担法律责任。 | | | | | | | | | | | | | | | | | | | | | | | | |
| 申请人 | 患者签名（指模）： 代办人签名（指模）：  代办人身份证号码：  代办人与患者关系： 代办人联系电话：  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | |
| 收单人（初核人）签名： 复核人签名： | | | | | | | | | | | | | | | | | | | | | | | | | |
| 备注 |  | | | | | | | | | | | | | | | | | | | | | | | | |

注：收款账户必须为本人银行账户，如有特殊情况请提供直系亲属银行账户，并签署个人承诺书。